Medicaid Information Bulletin

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REQUIRED FOR

- **Providers of physician services (physicians, osteopaths, pediatric or family practitioners, group practices, public health department clinics, federally qualified health centers, rural health centers)**

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00 - 101 Clinically Based Computer Auditing Program for Claims Payment: Physician Services

Effective for claims with a date of service on or after November 15, 2000, a clinically based computer auditing program will be implemented as part of the Medicaid Management Information System. Highlights of the program are:

- It allows enhanced automation and evaluation of claims.
- It is based on accepted industry standards and guidelines to verify the coding accuracy of professional claims.
- It identifies appropriate coding of procedures eligible for reimbursement.
- Payment for services will be more consistent and appropriate.
- Some state-specific editing will more fully support Medicaid policy.

Similar programs are already in use locally by some commercial third party payers.

Current policy and/or initial review processes for services requiring prior authorization, for procedures considered cosmetic, experimental or unproven, and for the use of unlisted or nonspecific procedure codes will not change.

Policies Supported by the Clinically Based Computer Auditing Program

The computer auditing program supports the Medicaid policies listed below:

1. New and Established Patient Codes

Medicaid policy requires patients to be identified as new or established. Information is on file for three years. If an inappropriate code is used, the system will add the appropriate code and pay the claim.

2. Age

For age specific procedures, the patient's age must be within the designated range. Age conflict is identified when a patient's age is outside the designated age range for the procedure. A line may be added to the claim with the appropriate code, and payment will be made.

3. Gender

For gender specific procedures, the patient's sex must be appropriate. Gender conflict is identified when a patient's sex does not match the gender required for the procedure. A line will be added to the claim with the appropriate code, and payment will be made.

Provider Specific Policies Supported by the Clinically Based Computer Auditing Program

Implementation of the computer auditing program affects coverage of dental, lab, physician and anesthesiology services. Provider specific bulletins are being issued separately to dentists and laboratories. These bulletins are available on the World Wide Web at

www.health.state.ut.us/medicaid/html/provider.html

Physician Services

The remainder of this bulletin describes Medicaid policies supported by the clinically based computer auditing program. There are also brief descriptions of policy changes and clarifications. Before describing the policy changes, we want to remind you that the clinically based computer auditing program fully supports current policy regarding assistant surgeon, surgical procedures, incidental procedures and laboratory procedure panels.

- **Assistant Surgeon**
  An assistant surgeon is authorized on specific procedures only. Use of an assistant surgeon on a procedure not authorized for an assistant will be denied payment. Refer to the list titled Procedures Not Authorized for Assistant Surgeon, included with the Physician Services manual, for procedure codes. (Reference: Utah Medicaid Manual for Physician Services, SECTION 2, Physician Services, Chapter 2, Covered Services, item 11.)

- **Surgical Procedures**
  When an all-inclusive code exists, which defines a procedure or surgery, providers must use that procedure to bill. The claim should not be submitted with the procedure broken into component codes. The auditing program supports package surgical procedure auditing. Unbundling is a major area to be edited. Unbundling occurs when an all-inclusive code exists which defines a procedure or surgery, but a claim is submitted with the procedure broken into component codes. The clinical auditing program will rebundle the unbundled codes, including pre and postoperative services, into the correct code.

- **Incidental Procedures**
  - Catheter placement for injection procedures is an integral part of the injection procedure and does not warrant additional payment.
  - Injection procedure for myelography and/or CT scan (code 62284) is an integral component of the primary procedure and does not warrant separate reimbursement.
  - Fluoroscopy, codes 76000 and 76001, is identified as incidental to all other procedures which, by their nature, require fluoroscopy as an integral part of the primary diagnostic procedure or are included in the professional component of the procedure. No additional payment will be made.
  - Many codes in the 70000, 80000, and 90000 series are considered incidental or mutually exclusive to other Evaluation and Management services, diagnostic procedures, major surgical procedures, or specialty procedures and do not warrant additional payment. It is logistically impossible to identify every incidental or mutually exclusive edit that may occur on a claim. It may be necessary to evaluate some of these edits on an individual basis after implementation of the clinically based computer auditing program.

- **Laboratory Procedure Panels**
  Laboratory procedure panels must be billed as directed. Panels will be edited for unbundling. Inappropriately billed codes will either be denied or rebundled to the appropriate panel. (Reference: Utah Medicaid Manual for Physician Services, SECTION 4, Laboratory. Chapter 3, Limitations, item 5.)

Physician Services: Changes and Clarifications

There are changes to Medicaid policy in SECTIONS 2, 3 and 4 of the Utah Medicaid Manual for Physician Services. Replacement pages are attached to update the Provider Manual. A vertical line in the margin of a page indicates where text was changed or added. Pages revised and attached are:

- SECTION 2, Physician Services: pages 4 through 9, 14 - 15, and 18 through 21.
- SECTION 3, Reimbursement For Anesthesiology: pages 4 through 9.

Changes are effective for claims with a date of service on or after November 15, 2000. A brief description of changes follows. For complete information, refer to the revised policy pages attached.

SECTION 2, PHYSICIAN SERVICES

There are revisions to both Chapter 2, Covered Services, and Chapter 3, Limitations. Changes are described briefly by chapter and item number.

Chapter 2, Item 3, After-Hours Service

Medicaid policy regarding the use of after-hours office service codes will be as follows:

3. After-hours office visit codes, 99050, 99052, 99054, and 99058 may be used by a private physician, primary care provider, who responds to treat an established patient in the physician's private office for a medical emergency, accident or injury after regular office hours. A private physician or physician group with established evening/weekend office hours, or a free standing urgent care facility which operates as a physician office, may also use these after-hours service codes. Only one of the after-hours office codes can be used per visit in addition to the E/M or service code.

   Limitations on use of after-hours office visit codes

   Limitations on use of the after-hours office visit codes are specified in policy. Refer to item 3 on page 5 attached.

Chapter 2, Item 4, Surgical procedures are covered as "package" services

A new sub-item "f" is added as follows:

f. Procedures identified as "add on" will be adjudicated according to the multiple surgery ranking.

Chapter 2, Item 8, Procedures exempt from the "package definition"

This item is revised as follows:

8. Procedures exempt from the "package definition" are starred procedures (*) identified in the CPT Manual. These procedures are relatively minor and have variable pre and postoperative periods. Therefore, separate payment for an E/M visit may be made.

Chapter 2, Items 12, 13, 14: use of diagnostic procedure codes

These items are revised as follows:

12. An evaluation and management (E/M) code and a diagnostic procedure code will generally not be covered separately on the same date of service. This includes service in the Emergency Room.

13. Diagnostic procedures performed along with larger, major therapeutic procedures are considered incidental to the major procedure, and no additional payment is warranted. Examples are a diagnostic laparoscopy and an open surgical procedure, or a diagnostic arthroscopy and a surgical arthroscopy. Payment will not be made for both procedures on the same day or during the same operative session.

14. Separate procedures as identified in the CPT guidelines are commonly carried out as an integral part of a total service and, as such, do not warrant separate payment. However, these procedures have the potential to be carried out independently of other services. In such cases, when a service is identified as a separate procedure, and it is the only procedure provided for a patient on a single date of service, separate reimbursement may be made.

The former item 15 has been deleted, and subsequent items are renumbered as 15 through 23.

Chapter 2, Items 25, 26: Surgical supplies

These items are revised as follows:

25. Surgical supply reimbursement is included in "package" surgical procedures in an office. Separate payment will not be made.

    Procedure code 99070 will not be covered for the purpose of obtaining "incidental supplies" for procedures provided in the office. This code is incidental to the office visit and/or service, and additional payment will not be made

26. In the occasional, unusual circumstance that additional supplies may be warranted by the nature of the surgical procedure performed, a surgical tray can be billed using code A4550.

Chapter 2, Item 28: Hemophilia Case Management

This item revised to update information about the sole source provider, who is now University Home Infusion Services.

Chapter 2, Item 32, Maternity Care, High Risk Pregnancy

Sub-item E, High Risk Pregnancy, lists codes and other services which may be covered. Policy is added to state that Fetal Non-stress Test (Code 59025) will be covered only for potentially high risk patients. Use of this test should be limited to high-risk patients 32 weeks gestation and beyond who have hypertension, diabetes, a history of a previous stillbirth, or when there is a decrease or absence of fetal movement.

SECTION 2, PHYSICIAN SERVICES

Chapter 3, Limitations on Physician Services

Effective for claims with a date of service on or after November 15, 2000, Medicaid policy regarding the limitations on physician services is modified. The changes explained below are listed by item number in the Utah Medicaid Manual for Physician Services, SECTION 2, Chapter 3, LIMITATIONS. Changes are supported by the clinically based computer auditing program.

Chapter 3, Item C, Coverage of some procedures identified by CPT codes

A new item 'C' is added to clarify coverage which is limited because of the nature, intensity, or relationship to other procedures performed during or related to other services. These include minor procedures, duplicate procedures, mutually exclusive procedures, and Incidental procedures. For complete information, refer to page 17 attached, item C.

Chapter 3, Item D, Modifiers

A new item 'D' is added to state policy regarding coverage of modifiers. Also, policy now states that modifiers 25, 26, and 27 will not be recognized. For more information, refer to page 17 attached.

Chapter 3, Item E, Laboratory procedures

Three limitations on the following laboratory procedures are added: urinalysis using code 81002; blood gas determination (82800); and pulse oxymetry (94760). For more information, refer to page 18 attached.

SECTION 3, REIMBURSEMENT FOR ANESTHESIOLOGY

SECTION 3, ANESTHESIOLOGY, of the Utah Medicaid Manual for Physician Services, has also been updated. Changes are effective for claims with a date of service on or after November 15, 2000. Changes are described briefly below.

The following sentences are added to the first paragraph of Chapter 3, REIMBURSEMENT FOR ANESTHESIA, on page 4: "Anesthesia is a global service just as the surgical procedure for which it is given. No pre or postoperative services will be recognized for separate payment, including those for pain management. Exception: Post C-section pain management is covered because a catheter is in place, no extra time or equipment is involved, nurses provide administration and management."

The following sentences are added to the first paragraph of Chapter 4, MULTIPLE PROCEDURES, on page 6: "This is true for obstetrical anesthesia as for all other anesthesia administration. Obstetrical anesthesia which begins as routine for vaginal delivery and goes to a C-section will only be reimbursed for one anesthesia administration, usually at the C-section level. Billing of two anesthesia administrations for same patient, same date of service, same provider will be denied."

Chapter 4 - 1 is renamed "Additional Procedures and Obstetrical Anesthesia." The first sentence and two sub-items are revised as follows:

"Procedures completed in addition to delivery may be paid the basic values for both procedures in the following circumstances:

- Epidural for labor and delivery followed by tubal ligation on the same date of service or a day following.
- Caesarean delivery followed by pain management/morphine injection during post-partum recovery."

Under Chapter 7, QUALIFYING CIRCUMSTANCES, on page 9, a note is added regarding the use of code 99140, anesthesia complicated by emergency conditions. "Note: Use of code 99140 will not be covered as a routine add on for obstetrical anesthesia. Most deliveries are unscheduled, but not high risk or emergent."

SECTION 4, LABORATORY SERVICES

SECTION 4, LABORATORY SERVICES, of the Utah Medicaid Manual for Physician Services, has also been updated. The following statement is added to Chapter 3, LIMITATIONS, on page 9: "Inappropriately billed codes will either be denied or rebundled to the appropriate panel." The clarification is effective for claims with a date of service on or after November 15, 2000. ☐